

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/17/2010
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - WINDWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 220 LONGMIRE RD CLINTON, TN 37716		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS A revisit was completed at Golden Living Center-Windwood on November 17, 2010, following acceptance of the Allegation of Compliance to remove the Immediate Jeopardy for F 333 and F 520. The revisit revealed the corrective actions implemented on November 9, 2010, removed the Immediate Jeopardy at F 333 and F 520, but noncompliance continues at a "D" level for F 333 and F 520, as evidenced by the findings at tags F 333 and F 520. The "G" level citation at F 323 and others previously cited also remain outstanding. The facility is required to submit a plan of correction for all outstanding tags.	{F 000}			
{F 157} SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	{F 157}	F157 Resident Resident #21 had been discharged Affected Residents Residents with change of condition Have the potential to be affected by this alleged deficient practice. System changes Morning meeting will review physician orders, nurse notes and 24 hour report to confirm physician notification on change of condition Education to nursing staff by DCE/designee on timely notification to physician on any change of condition. Monitoring Audits of 5 residents with change of condition will be performed weekly x 4, monthly x 2 to verify physician notification has occurred. Results of audits will be discussed in QA&A X 3 months. The meeting is attended by Executive Director, Director of Nursing (DNS), Assistant Director of Nursing (ADNS), Medical Director, Social Service, Activities, Dietary and Resident Assessment Coordinator and is held monthly.	11/30/10	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

11/12/2010 14:24

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HEALTH CARE FACILITY

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FORM APPROVED
OMB NO. 0938-0391DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 157}	<p>Continued From page 1</p> <p>change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview, the facility failed to notify the physician for a change in condition for one resident (#21) of twenty-five residents reviewed.</p> <p>The findings included:</p> <p>Resident #21 was admitted to the facility on June 1, 2010 with diagnoses including End Stage Renal Disease, Congestive Heart Failure, Hypertension, Wound Right Lower Extremity, and Atrial Fibrillation.</p> <p>Medical record review of the Non Pressure Ulcer Skin Condition report dated June 8, 2010 revealed "...Wound bed (at) (R) (right) posterior leg 16.8 x (by) 9.6 x 0.3 cm (centimeters). Wound bed dark pink in color. Wound bed outer edges irregular in shape...(large) amt (amount) s/s (serosanguinous) drainage..."</p> <p>Medical record review of the Non Pressure Ulcer Skin Condition report dated June 15, 2010 revealed "...Posterior (R) (right) leg wound bed...dark pink in appearance (with) lg (large) amt (amount) s/s (serosanguinous) exudate..."</p>	{F 157}			

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(F 157)	<p>Continued From page 2</p> <p>Medical record review of the Non Pressure Ulcer Skin Condition report dated June 29, 2010 revealed "...Posterior (R) leg wound...wound bed dark pink (with) thin layer of yellow material...(no) odor noted..."</p> <p>Medical record review of the Non Pressure Ulcer Skin Condition report dated July 7, 2010 revealed "... (R) posterior leg from previous hematoma. Wound continues to be dark pink (and) yellow slimy film...(no) odor noted..."</p> <p>Medical record review of a Nursing Progress Note dated July 19, 2010 revealed "...Dressing to right calf changed per resident's request. Dressing had greenish brown drainage present with slight odor when it was removed. No signs of redness or inflammation is observed at site..."</p> <p>Medical record review of a Nursing Progress Note dated July 22, 2010 revealed "...Admitted with surgical wound to @ (right) posterior leg from a hematoma. Area 13.6 cm x 6.3 cm x 0.2 cm wound bed pink with some yellow noted. Small amt (amount) of yellow serous exudate. Wound bed outer edges irregular and flat. Surrounding tissue dry/flaky tissue with 1+ (plus) edema noted. Wound slightly malodorous. No c/o (complaint of) pain or discomfort. Received T.O. (telephone order) per (named physician) to obtain wound culture and start Keflex 250 mg (milligrams) po (by mouth) tid (three times a day) x (times) 5 days...Resident scheduled to start Keflex to promote wound integrity in the AM (morning) after wound culture is obtained. Patient had wound dressed today and does not want to undress wound for culture this evening..."</p>	(F 157)			

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{F 157}	Continued From page 3 Review of facility policy Notification of Change in Resident Health Status revealed "...The facility will consult the resident's physician, nurse practitioner or physician assistant...when there is:....significant change in the resident's physical...status...A need to alter treatment significantly...to commence a new form of treatment...Notification: Depending on the nursing assessment appropriate notification may be immediate to 48 hours..." Interview on October 25, 2010 at 3:40 p.m., with the Assistant Director of Nursing in the conference room confirmed the facility had failed to notify the physician of the decline in the wound on July 19, 2010 until July 22, 2010 (three days later).	{F 157}			
{F 226} SS=D	C/O #28477 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation, review of facility policy, and interview, the facility failed to fully implement the abuse policy for one resident (#16) with an injury of unknown origin of twenty-five residents reviewed. The findings included:	{F 226}			

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{F 226}	<p>Continued From page 4</p> <p>Resident #16 was admitted to the facility on May 26, 2008, with diagnoses including Paraplegia, Osteoporosis, Rheumatoid Arthritis, and Hypertension.</p> <p>Review of the facility investigation and a signed written statement from LPN #2 (Licensed Practical Nurse) dated July 9, 2010 revealed "...the resident had complaints of nausea, vomiting, and no complaints of pain." Continued review of the facility investigation and hand written statement revealed the LPN (#2) completed an assessment and noted "...R (right) thigh pink and swollen; and bruising to the R (right) inner leg..."</p> <p>Continued review of the facility investigation and a signed written statement from CNA #1 (Certified Nursing Assistant) revealed "...when giving peri-care (incontinence) on July 8, 2010 noted swelling and bruising on R (right) leg...didn't tell anybody."</p> <p>Review of the facility Abuse Policy revealed "...injuries of unknown source are reported immediately to the Executive Director of the facility...all investigations shall be conducted by the ED (Executive Director) or DNS (Director of Nursing Services)..."</p> <p>Interview with the LPN #2, on October 27, 2010 at 1:15 p.m., in the 200 hall revealed "...on July 9, 2010 resident was complaining of nausea and vomiting, and since...legs are paralyzed...thought maybe pain was playing a role and not able to feel it...an assessment was started...the right thigh was pink and swollen, and was bruising to the right inner thigh. An x-ray was ordered (positive for right femur fracture) and the Director</p>	{F 226}	<p>F226 Resident Resident # 16 received treatment and has had no further issues and as per 2567 an investigation was conducted with no evidence of abuse.</p> <p>Affected Residents Residents residing in facility have the potential to be affected by this alleged deficient practice. Skin audits were conducted on residents currently residing in facility and reviewed by DNS and identified skin concerns were addressed according to protocol.</p> <p>System changes Weekly skin assessments and Bathmen will be brought to morning meeting and reviewed by IDT.</p> <p>Education provided to staff by DNS/ED/Designee related to Abuse and Neglect policy and protocol for reporting – this included timely reporting, what is abuse and neglect and responsibility in reporting. Also included weekly skin assessment and documentation requirements will also be included in the education.</p> <p>Monitoring In morning meeting, IDT will review weekly skin assessments to confirm that skin concerns were addressed and investigated as per protocol.</p> <p>Any identified concerns will be reviewed in monthly QAA meeting. The meeting is attended by Executive Director, Director of Nursing (DNS), Assistant Director of Nursing (ADNS), Medical Director, Social Service, Activities, Dietary and Resident Assessment Coordinator and is held monthly</p>		11/30/10

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11/17/2010

NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - WINDWOOD

STREET ADDRESS, CITY, STATE, ZIP CODE

220 LONGMIRE RD
CLINTON, TN 37716(X4) ID
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{F 226}

Continued From page 5
of Nursing notified immediately."

{F 226}

{F 250}
SS=D483.15(g)(1) PROVISION OF MEDICALLY
RELATED SOCIAL SERVICE

{F 250}

The facility must provide medically-related social
services to attain or maintain the highest
practicable physical, mental, and psychosocial
well-being of each resident.

F250

Resident affected
Resident #14----has been seen by dentist and
received needed partial plate. Follow-up by SSD
was completed to determine that psychosocial
needs were met.This REQUIREMENT is not met as evidenced
by:
Based on medical record review, review of e-mail
correspondence, review of a dental referral list,
observation, and interview, the facility failed to
make a follow up appointment for dental services
for one resident (#14) of twenty five residents
reviewed.**Resident potentially affected**
Residents with dental concerns have potential
to be affected by this alleged deficient practice.
Oral evaluations were performed on current
residents who were not seen by dentist on last
two visits and reviewed for any dental concerns.
Identified concerns where referred as appropriate
for needed care.

The findings included:

Resident #14 was admitted to the facility on
October 9, 2006 with diagnoses including Multiple
Sclerosis. Medical record review of the Minimum
Data Set (MDS) dated August 29, 2010 revealed
the resident with no loss in short or long term
memory, independent with decision making skills,
and had experienced no weight loss.**Systemic changes**
Oral evaluation will be performed on new
admission/readmissions and quarterly and as
needed. Referral book placed at nursing station
for staff to alert SSD of any identified concerns-
this book will be brought to morning meeting by
SSD /designee and reviewed by the team for any
further needs.Observation on October 26, 2010 at 10:00 a.m.,
revealed the resident had two missing front teeth.
Interview with the resident at this time revealedEducation was given to nursing staff as to
identifying change of condition, dental needs
and use of referral book by DCE/designee.
Education to SSD by ED on verifying dental list.

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{F 250}	Continued From page 6 concerns regarding the missing teeth. Further interview revealed that one front tooth had been extracted on June 9, 2010 and one implanted tooth had dropped out of the socket. Continued interview with the resident revealed the resident had concerns regarding the status of follow up dental service and expressed embarrassment related to the missing front teeth. Medical record review of nursing, dietary, and social service progress notes, from June 10, 2010 through October 2010 revealed no documentation of any lost teeth and the resident's weight as stable at 152 pounds. Medical record review of the MDS dated August 29, 2010 revealed no teeth lost. Review of e-mail correspondence between the facility and the dental service dated August 24, 2010 revealed that the next dental visit was set for October 15, 2010 and resident #14 would be included on the list to be seen. Review of the dental referral list prepared by social services for the October 15, 2010 dentist visit revealed resident #14 was not included on the list. Interview with the social worker on October 27, 2010 at 9:00 a.m., at the north nurse's station confirmed the social services had failed to ensure resident #14 was scheduled for a follow up visit with dental services on October 15, 2010.	{F 250}	Monitoring DNS/Designee will perform audit of 10 residents to review oral evaluation to verify that any residents with dental concerns are in referral book to be follow up by dentist. This audit will be performed monthly for three (3) months ED will review completed list of referrals referencing the referral book monthly x 3 to confirm residents identified in book are on list to see dentist. Results of audits will be discussed in QA&A X 3 months. The meeting is attended by Executive Director, Director of Nursing (DNS), Assistant Director of Nursing (ADNS), Medical Director, Social Service, Activities, Dietary and Resident Assessment Coordinator and is held monthly.		11/30/10
{F 323} SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	{F 323}			

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GOLDEN LIVINGCENTER - WINDWOOD

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220 LONGMIRE RD

CLINTON, TN 37710

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{F 323}	<p>Continued From page 7</p> <p>adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigations, review of the manufacturer's instructions, observation, and interview, the facility failed to ensure safety devices were in place and failed to implement new interventions to prevent falls for three residents (#9, #8, #11) resulting in harm for one resident (#9) of twenty-five residents reviewed.</p> <p>The findings included:</p> <p>Resident #9 was admitted to the facility on February 2, 2010 with diagnoses including Diabetes, Renal Failure, Hypertension, and Peripheral Vascular Disease.</p> <p>Medical record review of the Minimum Data Set dated February 11, 2010, revealed the resident had short term memory problems only, moderately impaired cognitive skills for daily decision making, and required extensive assistance for transfers.</p> <p>Medical record review of a fall risk assessment dated February 2, 2010 revealed the resident was at risk for falls.</p> <p>Medical record review of a physician's order dated February 19, 2010 revealed "Bed/Chair alarm: check for battery function every shift."</p>	{F 323}	<p>F323</p> <p>Residents affected: Resident #9 was reviewed by IDT for appropriateness of current interventions and a bracket was installed to ensure proper use of alarm. Resident #8 was screened by therapy to ensure that current restraint remains the intervention of choice to provide safe environment. Resident #11's plan of care was reviewed by the IDT for appropriateness of current interventions. Alarms and restraints were checked by facility staff to assure proper operation and batteries were replaced.</p> <p>Residents potentially affected: Residents of the facility who have a history of falls have the potential to be affected by the alleged deficient practice. The interdisciplinary team met to review current residents with alarms/restraints for appropriateness. Brackets were applied to beds as needed for placement of alarms while in bed. Alarms and restraints were checked by facility staff to assure proper operation and batteries were replaced.</p>	

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(F 323)	<p>Continued From page 8</p> <p>Review of a facility investigation dated March 14, 2010 revealed "...Objective/underlying illness/Dx (diagnosis): Hx (history) of falls; Impaired safety awareness/judgment...walking down hall-holding bed/chair alarm...intervention used prior to fall: Bed/chair alarm; pain assessment; Bed in low position; safety cues/reinforcement/reminder; call light w/in (within) reach...Recommendations and Interventions Post Fall: Bed/Chair alarm; pain assessment; Bed in low position; safety cues/reinforcement/reminder; Call light w/in reach; other use bed alarm when in bed..."</p> <p>Review of a facility investigation dated April 14, 2010 revealed "...Res. (resident) transferred self (without) assistance from bed-found on floor...one shoe on (and) one shoe off. Alarm intact beside...Continue present interventions...intervention used prior to fall: Night light...change in footwear; Assistive device w/in reach...Recommendations and Interventions Post Fall...Change in footwear; Night light; Assistive device w/in reach..."</p> <p>Medical record review of a Change in Condition Report dated April 15, 2010 revealed "...Res. (resident) has Hx (history) of falls d/t (due to) impaired safety awareness, Bed was in low position, call light was in easy reach (res. did not use call light for assistance)...Res got (up) unassisted (with)...alarm monitor-was lying on the floor on...left side..."</p> <p>Medical record review of a hospital consultation report dated April 16, 2010 revealed "...Reason for Consultation: Right hip fracture or pain...Development of dysplasia of the hip with degenerative joint disease, but no acute fracture..."</p>	(F 323)	<p>Systemic changes: The interdisciplinary team met to review residents with alarms/restraints for appropriateness. These will be reviewed during the weekly fall review meeting. Event investigations will be reviewed in morning meeting by ED/Designee and discussed by the IDT for completeness of investigation and implementation of new interventions. The CNAs will be checking alarms /restraints with rounds for proper placement, function, need for replacement, etc. This will also be checked with non-clinical rounds performed by the department heads 3 times weekly. The nurses will be replacing batteries in alarms on the 15th of the month.</p> <p>The DCE/designee has educated nursing staff on fall interventions including alarms/restraints, purpose and utilization of brackets and purpose, and licensed staff on completion of event investigation to include thorough investigation, implementing new interventions, assessment and appropriate documentation. Education provided to IDT on investigation process by Clinical consultant.</p> <p>Monitoring changes: DNS/Designee will do audits 3x weekly on random shifts of fall interventions to include alarm/restraints on 5 residents x 4 weeks then monthly x 2. DNS/Designee will review audits for any issues. ED/Designee will discuss investigations in morning meeting to review for completeness.</p> <p>Results of audits will be discussed in QA&A X 3 months. The meeting is attended by Executive Director, Director of Nursing (DNS), Assistant Director of Nursing (ADNS), Medical Director, Social Service, Activities, Dietary and Resident Assessment Coordinator and is held monthly.</p>	11/30/10	

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{F 323}	<p>Continued From page 9</p> <p>Review of a facility investigation dated August 4, 2010 revealed "...Return from one day surgery (at) 9:00 p.m. Had not had dinner. Sat resident in bed (with) (overbed) table and meal. Resident found in floor c/o (complaining of) R (right) hip pain. Call MD (Physician)...sent out for eval (evaluation)...Adm (admitted (with) (right) hip fx (fracture)...attempted to get OOB (out of bed) fell in floor, bed alarm was on-disconnected..."</p> <p>Medical record review of a x-ray report dated August 5, 2010 revealed "...Patient fell with pain...Impression: Comminuted right-sided intertrochanteric fracture...Deformity of the right femoral head, with a shallow acetabulum..."</p> <p>Observation on October 25, 2010 at 8:30 a.m., revealed the resident lying in the bed with the personal alarm clipped to the resident's shirt with the alarm box lying in the bed next to the resident.</p> <p>Observation on October 26, 2010 at 3:15 p.m., revealed the resident lying in the bed with the personal alarm clipped to the resident's shirt with the alarm box lying at the top of the bed.</p> <p>Observation on October 28, 2010 at 2:25 p.m., revealed the resident lying in the bed with the head of the bed elevated, the personal alarm clipped to the resident's sweater, and the alarm box lying on the bed under the pillow.</p> <p>Observation with RN (Registered Nurse) #1 on October 28, 2010 at 3:30 p.m., revealed the resident lying in the bed with the personal alarm clipped to the resident's shirt, and the alarm box lying on the bed under the pillow.</p>	{F 323}			

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{F 323}	<p>Continued From page 10</p> <p>Observation with the Staff Development Coordinator on October 27, 2010 at 8:15 a.m., revealed the resident lying in the bed with the personal alarm clipped to the resident's shirt, with the alarm box lying on the bed next to the resident.</p> <p>Review of the manufacturer's instructions for the personal monitor revealed "...Bed Use...mount the bed mounting holder to the side of the headboard facing the mattress...adjust the screw knobs so that the holder is secure...fasten the monitor to the holder, facing the patient..."</p> <p>Interview on October 27, 2010 at 8:15 a.m., with the Staff Development Coordinator in the resident's room confirmed the alarm box is not to be lying on the bed.</p> <p>Interview on October 27, 2010 at 8:30 a.m., with the Assistant Director of Nursing (ADON) in the conference room confirmed it was undetermined if the alarm was sounding at the time of the fall on April 14, 2010. Continued interview with the ADON confirmed no new interventions had been implemented after the fall on April 14, 2010 resulting in a fall with a fracture on August 4, 2010.</p> <p>Resident #8 was admitted to the facility on April 7, 2009 with diagnoses including Dementia, Depression, Osteoporosis and Cerebral Vascular Accident. Medical record review of the Minimum Data Set dated January 22, 2010 revealed the resident had long and short term memory problems and moderately impaired cognitive skills for daily decision making.</p>	{F 323}			

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(F 323)	<p>Continued From page 11</p> <p>Medical record review of the care plan updated August 25, 2009 revealed the resident had a history of falls and the facility had implemented one half bed rails, bed/chair alarm, and a soft belt when in the wheelchair.</p> <p>Medical record review of a fall risk assessment dated June 10, 2010 revealed the resident was at high risk for falls.</p> <p>Medical record review of a facility investigation dated July 17, 2010 revealed the resident fell without injury. Continued review of the facility investigation revealed the use of the soft belt at the time of the fall had not been addressed.</p> <p>Medical record review of a post fall investigation summary completed and signed by the Interdisciplinary Team dated July 19, 2010 revealed the resident "...attempted to get out of wheelchair sat in floor...make sure lap belt in place..."</p> <p>Observation on October 25, 2010 at 10:45 a.m., revealed the resident seated in a wheelchair with a soft belt in place.</p> <p>Interview with the Director of Nursing on October 25, 2010 in the conference room confirmed on July 17, 2010 the resident was to have a soft belt while in the wheelchair, the use of the soft belt at the time of the fall was not addressed in the investigation. Continued interview confirmed as per the post fall investigation the resident fell out of the wheelchair and the only Interdisciplinary Team recommendation was to ensure the soft belt was in place.</p> <p>Resident #11 was admitted to the facility on</p>	(F 323)			

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NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - WINDWOOD

STREET ADDRESS, CITY, STATE, ZIP CODE

220 LONGMIRE RD
CLINTON, TN 37716

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{F 323}	Continued From page 12 September 16, 2009 with diagnoses including Alzheimer's Disease, Hypothyroidism, and Anxiety. Medical record review of the care plan dated August 12, 2010 revealed the resident had a history of fall, was high risk for falls, and the facility had implemented bed in low position. Review of a fall investigation dated September 25, 2010 revealed "...attempted to transfer self out of bed...slid into floor between bed and night stand...no apparent injury..." Continued review of the fall investigation revealed no documentation of what position the resident's bed was in at the time of the fall. Review of a post fall investigation summary completed and signed by the Interdisciplinary Team dated September 29, 2010 revealed "...keep bed low to floor when in bed." Interview with the Assistant Director of Nursing on October 27, 2010 at 10:30 a.m., in the conference room confirmed no new intervention was implemented after the fall on September 25, 2010.	{F 323}		
{F 333} SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: A revisit was completed at Golden Living Center Windwood on November 17, 2010, following acceptance of the Allegation of Compliance to	{F 333}		

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(F 333)	<p>Continued From page 13</p> <p>remove the Immediate Jeopardy for F 333. The revisit revealed the corrective actions implemented on November 9, 2010, removed the Immediate Jeopardy at F 333, but noncompliance continues at a "D" level for F 333, as evidenced by the findings at tag F 333.</p> <p>Based on survey results dated November 2, 2010, the facility failed to prevent a significant medication error for one (#21) resident of thirty-six residents reviewed.</p> <p>The findings included:</p> <p>The facility provided an acceptable Credible Allegation of Compliance with a compliance date of November 9, 2010. An onsite visit was completed on November 17, 2010 to validate compliance. The credible allegation was validated on November 17, 2010, at 1:00 p.m. Validation of the Credible Allegation of Compliance was accomplished through medical record review and interview with licensed nurses. The facility provided evidence of inservice and training records for all nursing staff related to verification of admission orders, printing Coumadin medication administration records, and the five rights of medication administration. Included in the validation process was review of facility tools used to document ongoing monitoring of verification of medication orders and medication administration.</p> <p>The facility remained out of compliance at a Scope and Severity level of "D" No actual harm with potential for more than minimal harm that is not immediate jeopardy. The facility will remain out of compliance until it provides an acceptable plan of correction to include the continued</p>	(F 333)	<p>F333 Resident Resident is discharged from facility</p> <p>Affected Residents New admissions to facility receiving Coumadin therapy have the potential to be affected by this alleged deficient practice. Residents receiving anticoagulant therapy were audited to ensure MAR's in place and correct dosage according to orders completed by ADNS.</p> <p>Systemic Changes</p> <p>Chart reviews will be conducted within 24-72 hours of admission/readmission to include verification of admission orders. The process is ongoing to monitor verification of order and MAR's are printed correctly. Weekly audit of residents receiving Coumadin will be completed by ADNS/Designee to verify orders and correct dosage and validate both are in place. Monthly audit of MAR's at first of month to verify MAR's were printed with recaps process for residents receiving Coumadin. Nurses will receive verification from fax machine that medication orders have been faxed to pharmacy.</p> <p>Education by DCE/Designee to 100% of currently active licensed staff re: Pharmacy protocol including ordering, confirming new medication orders, how and when to use E-KITS, and how to return medication and not borrowing medications from other residents including those who have been discharged, printing of MAR's, and verifying new admission orders.</p>		

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{F 333}	Continued From page 14 monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 333}	Monitor Cart / chart / MAR audit was developed and will be done randomly on 4 residents weekly x 2 months. Weekly PT/INR audit for residents receiving Coumadin	11/30/10	
{F 502} SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to obtain a physician ordered lab for the monitoring of anticoagulant therapy for one resident (#3) of twenty five residents reviewed. The findings included: Resident #3 was admitted to the facility on May 12, 2010 with diagnoses including Atrial Fibrillation, Congestive Heart Failure, and Dementia. Medical record review of a physician's order revealed "increase Coumadin from 4 mg (milligram) to 4.5 mg each day and follow up PT/INR (protime) (international normalized ratio) on October 21, 2010." Medical record review of laboratory reports revealed the facility drew the blood specimen "stat" (immediately) on October 26, 2010, (five days later) and received the PT/INR report on October 27, 2010. Medical record review of a physician order dated October 27, 2010, revealed	{F 502}	MAR audit at first of month to verify Coumadin MARs in place. Results of audits will be discussed in QA&A X 3 months. The meeting is attended by Executive Director, Director of Nursing (DNS), Assistant Director of Nursing (ADNS), Medical Director, Social Service, Activities, Dietary and Resident Assessment Coordinator and is held monthly. F502 Residents Resident #3's lab was obtained and doctor was notified of results. Affected residents Residents with orders for labs have the potential to be affected by this alleged deficient practice. An audit of routine ordered labs verifying results obtained was conducted and any identified issues were corrected. System changes A lab log will be implemented to record ordered labs. The lab log will assist with monitoring of orders, results and physician notification. Lab log will be brought to morning meeting and reviewed to identify any outstanding labs needs.		

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{F 502}	Continued From page 15 "...increase (Coumadin) 5 mg po (by mouth) QD (everyday)..." Interview on October 26, 2010 at 10:50 a.m., with Registered Nurse #2 revealed the order to complete the PT/INR on October 21, 2010 had not been processed or sent to the laboratory. Interview on October 27, 2010 at 11:00 a.m., in the conference room with the Administrator and the Director of Nursing confirmed the facility failed to complete the PT/INR as ordered on October 21, 2010 until October 26, 2010 (five days later).	{F 502}	Education completed by DCE/Designee related how to use lab log, reporting results, verifying lab orders. Education to start up team by consultant on how to use lab log to monitor system in morning meeting.	
{F 514} SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to ensure the medical record was complete for one resident (#21) of twenty-five residents reviewed. The findings included:	{F 514}	Monitoring Lab log to be brought to morning meeting by DNS/DESIGNEE and will verify with physician orders and nurses notes any new orders are on log, labs have been drawn and results have been received and appropriate notification to doctor has been completed. Monthly audit of ordered labs will be conducted by DNS/Designee. Results of audits will be discussed in QA&A X 3 months. The meeting is attended by Executive Director, Director of Nursing (DNS), Assistant Director of Nursing (ADNS), Medical Director, Social Service, Activities, Dietary and Resident Assessment Coordinator and is held monthly. F514 Resident Resident has been discharged from facility. Affected Residents Residents receiving wound care have the potential be affected by this alleged deficient practice Rounds were conducted by DNS to review current residents with wounds to verify care of wounds and documentation in place. Current residents were assessed for present wound status.	11/30/10

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HEALTH CARE FACILITY

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{F 514}	Continued From page 16 Resident #21 was admitted to the facility on June 1, 2010 with diagnoses including End Stage Renal Disease, Congestive Heart Failure, Hypertension, Wound Right Lower Extremity, Atrial Fibrillation, and was discharged from the facility on August 7, 2010. Medical record review of a physician's order dated June 1, 2010 revealed "... (right) leg wound Mepital dressing (and) cover (with) dry gauze, daily dressing change dry gauze but leave Mepital intact to wound bed (and) cleanse (with) normal saline (with) each dressing (change)..." Medical record review of a physician's order dated June 13, 2010 revealed "... Clean area on posterior RLE (right lower extremity) with wound cleanser. Cover open area with xeroform gauze. Cover with ABD pads and wrap with kerlix. Change drsg (dressing) daily and pm (as needed)..." Medical record review of the June 2010 treatment record revealed no documentation the treatment was provided on June 26, 27, 28, 29, and 30, 2010. Medical record review of a physician's order dated July 30, 2010 revealed "... Clean wound with a hibiclens sponge/wash cloth each day... then apply Silvadene to wound Qday (every day)... then apply 4 x (by) 4's and kerlix wrap..." Medical record review of the July 2010 treatment record revealed no documentation the wound care was provided on July 31, 2010. Interview on October 25, 2010 at 3:25 p.m., in the	{F 514}	System changes TAR will be brought to morning meeting and reviewed 3 x weekly by DNS/Designee for appropriate documentation. End of shift checklist for nurses to verify appropriate documentation on TARS. Weekly skin assessment / bathman reviewed by IDT in morning meeting - reviewing any identified issues with physician orders and TARS. Education provided to nursing staff related to daily documentation needs and expectations for wounds. Monitoring Review of TAR's 3x weekly in morning meeting Results of audits will be discussed in QA&A X 3 months. The meeting is attended by Executive Director, Director of Nursing (DNS), Assistant Director of Nursing (ADNS), Medical Director, Social Service, Activities, Dietary and Resident Assessment Coordinator and is held monthly.		11/30/10

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(F 514)	Continued From page 17 conference room with the Assistant Director of Nursing confirmed the medical record did not contain documentation the treatment was provided to the wound on the right lower extremity from June 26, 2010 through June 30, 2010 and July 31, 2010.	(F 514)			
(F 520) SS=D	c/o #26477 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	(F 520)	F520 Resident None named Residents affected Residents residing in facility have potential to be affected by this alleged deficient practice. Director of operations and clinical consultant attended QAA meeting on Nov 9, 2010 providing feedback to IDT on procedure, current action plans and follow up. Systemic changes Facility conducted an Ad-Hoc QA&A meeting on Nov. 09, 2010 to review event investigation for falls, System for dental referrals, pharmacy con- cerns, verifying Physician orders, ensuring Coumadin MARS are printing, Recap orders, obtaining new medications from pharmacy, Physician orders on admission and readmission and audit tools for areas identified above. Committee also reviewed plan for education for completing 100% of licensed nursing staff. This ad-hoc QA&A was attended By ED,DNS, ADNS, RN supervisor, Medical Director, DCE,DO,CSC, SSD, AD, MR, Resident Assessment Coordinator.		

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{F 520}	<p>Continued From page 18</p> <p>A revisit was completed at Golden Living Center Windwood on November 17, 2010, following acceptance of the Allegation of Compliance to remove the Immediate Jeopardy for F 520. The revisit revealed the corrective actions implemented on November 9, 2010, removed the Immediate Jeopardy at F 520, but noncompliance continues at a "D" level for F 520, as evidenced by the findings at tag F 520.</p> <p>Based on survey results dated November 2, 2010, the facility failed to ensure the Quality Assurance Committee inserviced all staff on all units related to verifying admission orders and ensuring Coumadin medication administration records had been printed, and failed to identify concern's with physician's orders not being sent to pharmacy.</p> <p>The findings included:</p> <p>The facility provided an acceptable Credible Allegation with a Compliance date of November 9, 2010. An onsite visit was completed on November 17, 2010, to validate compliance. Validation of the Credible Allegation of Compliance was accomplished through medical record review and interview with licensed nurses. The facility provided evidence of inservice and training records for all nursing staff related to verification of admission orders, printing Coumadin medication administration records, and the five rights of medication administration. Included in the validation process was review of facility tools used to document ongoing monitoring of verification of medication orders and medication administration.</p> <p>The facility remained out of compliance at a</p>	{F 520}	<p>Education Education provided by CSC on 11/06/10 to QA&A committee which included the: ED, DNS, DCE, SS, RNAC, RN Supervisor, RD, ADNS and medical records. Education covered: QA&A process, root cause analysis developing comprehensive plans to address concerns.</p> <p>Monitor The Director of Operations (DO) or the Clinical Services Consultant (CSC) will review the facilities Quality Assurance process to check that areas are evaluated, updated and have follow-up as needed x 3 months then quarterly X 3.</p>		11/30/10

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{F 520}	Continued From page 19 Scope and Severity level of "D" No actual harm with potential for more than minimal harm that is not immediate jeopardy. The facility will remain out of compliance until it provides an acceptable plan of correction to include the continued monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 520}		